SECTION 9

Medicare Advantage

Chart 9-1. MA plans available to virtually all Medicare beneficiaries

	CCPs					
	HMO or local PPO	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per county
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12
2012	93	76	99	60	100	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost-based plans, employer-only plans, and certain demonstration plans).

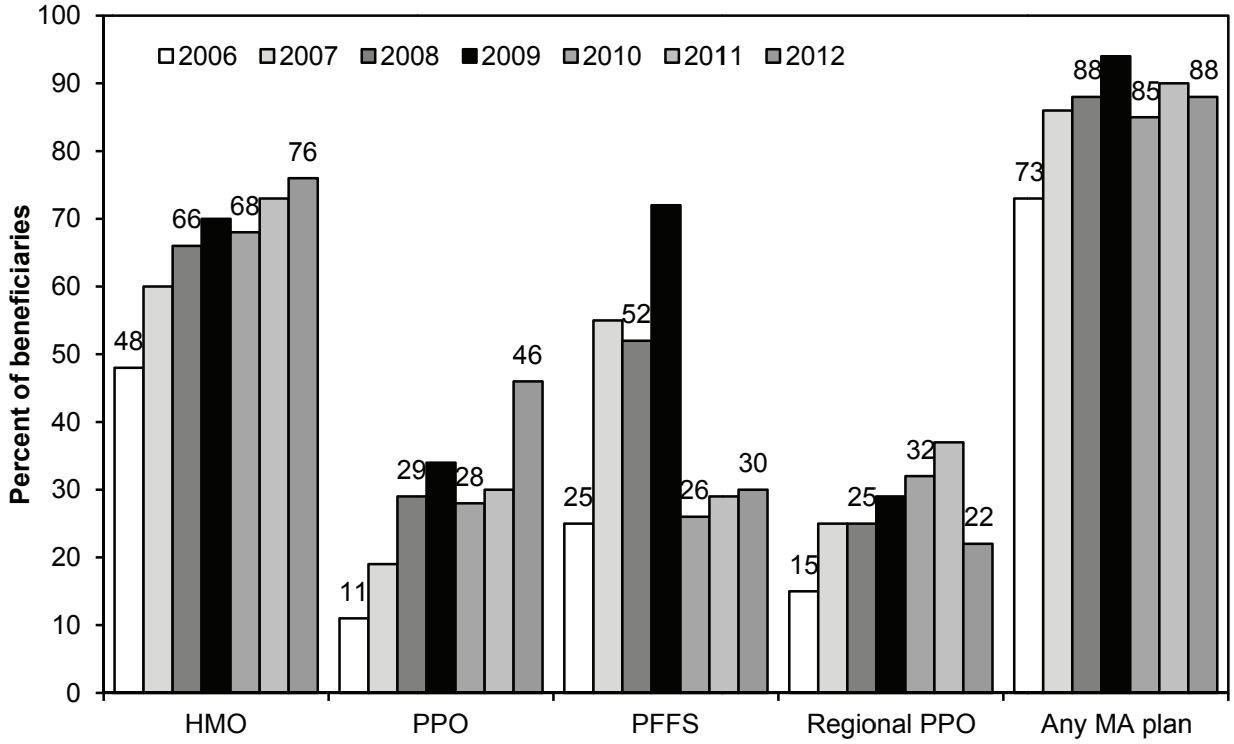
Source: MedPAC analysis of plan finder data from CMS.

- There are four types of plans, three of which are CCPs. Local CCPs include local PPOs and HMOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional CCPs (regional plans are required by statute to be PPOs) cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Since 2011, PFFS plans, which previously were not CCPs, are required to have networks in areas with two or more CCPs. In areas where there are not two or more CCPs, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.

- Local CCPs are available to 93 percent of Medicare beneficiaries in 2012—up from 67 percent in 2005. Regional PPOs are available to 76 percent of beneficiaries. The availability of MA PFFS plans has declined from 100 percent of beneficiaries in 2010 to 60 percent of beneficiaries in 2012. The decline is due to recent provider network requirements in most of the country. For the past seven years, virtually 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.

- The number of plans from which beneficiaries may choose in 2012 is about the same as last year. In 2012, beneficiaries can choose from an average of 12 plans operating in their counties. This number has decreased after peaking in 2008 and 2009, reflecting CMS's 2010 effort to reduce the number of duplicative plans and plans with small enrollment and the network requirements for PFFS plans.

Chart 9-2. Access to zero-premium plans with MA drug coverage, 2006–2012



Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service).

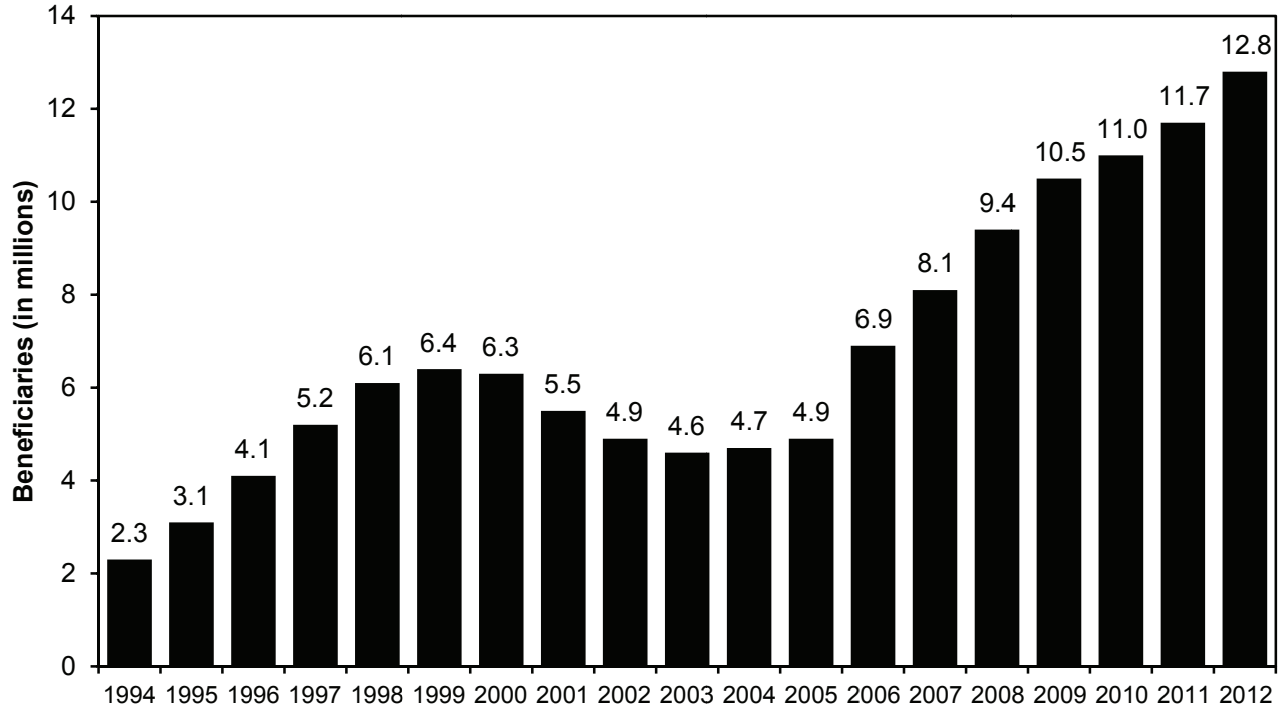
Source: MedPAC analysis of bid and plan finder data from CMS.

- Across all plan types, the availability of "zero-premium" plans—plans with no premium payments other than the Medicare Part B premium—has ranged from 85 percent to 94 percent since 2007. Most beneficiaries can obtain a Medicare Advantage–Prescription Drug (MA–PD) plan, an MA plan that includes Part D drug coverage, for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2012, 88 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 90 percent in 2011.

- Seventy-six percent of beneficiaries have zero-premium MA–PD HMOs available. MA–PD PPOs without premiums are less widely available, but are available to 46 percent of beneficiaries in 2012, up from 30 percent in 2011. However, zero-premium regional PPOs are less available than they have been in the past. PFFS plans offering zero premiums and Part D drug coverage are available to 30 percent of beneficiaries in 2012.

- In most cases, MA plan enrollees continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees' Part B premium obligation.

Chart 9-3. Enrollment in MA plans, 1994–2012



Note: MA (Medicare Advantage).

Source: Medicare managed care contract reports and monthly summary reports, CMS.

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 12.8 million enrollees (26 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands) February 2009	February 2010	February 2011	February 2012	Percentage change 2011–2012
Local CCPs	7,625	8,534	9,993	11,382	14%
Regional PPOs	377	760	1,132	930	–18
PFFS	2,353	1,657	588	518	–12

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations and local PPOs.

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew by 14 percent over the past year. Enrollment in regional PPOs and in PFFS plans declined. Combined enrollment in the three types of plans grew by 10 percent from February 2011 to February 2012.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2012

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
US total	48,799	17%	6%	2%	1%	1%	27%
Alabama	871	14	6	1	0	0	22
Alaska	68	0	0	0	0	0	1
Arizona	959	34	3	1	1	0	38
Arkansas	547	7	3	3	4	0	16
California	4,934	35	1	0	0	0	37
Colorado	655	26	3	0	1	4	34
Connecticut	581	16	4	1	0	0	21
Delaware	155	3	1	0	0	0	5
Florida	3,470	25	2	7	0	0	35
Georgia	1,296	6	10	4	4	0	24
Hawaii	215	15	12	14	0	4	45
Idaho	239	10	16	0	3	1	31
Illinois	1,889	6	3	0	0	0	10
Indiana	1,037	2	9	7	2	0	19
Iowa	527	6	6	1	1	2	14
Kansas	444	4	5	0	3	0	12
Kentucky	784	3	7	6	1	1	17
Louisiana	709	22	1	2	1	0	26
Maine	273	9	6	0	0	0	16
Maryland	815	3	2	0	0	3	9
Massachusetts	1,092	15	2	1	0	0	18
Michigan	1,709	11	13	1	1	0	26
Minnesota	811	15	5	2	0	26	47
Mississippi	511	5	3	2	2	0	11
Missouri	1,029	15	5	1	2	0	23
Montana	175	0	9	1	7	0	16
Nebraska	285	6	3	1	3	1	13
Nevada	372	27	3	2	1	0	33
New Hampshire	228	1	2	0	2	0	5
New Jersey	1,364	13	1	0	0	0	14
New Mexico	325	19	8	0	1	0	28
New York	3,067	23	7	2	1	0	32
North Carolina	1,546	11	4	2	3	0	19
North Dakota	110	0	1	0	3	7	11
Ohio	1,949	15	16	4	0	1	37
Oklahoma	619	11	3	0	2	0	16
Oregon	644	21	20	0	0	0	42
Pennsylvania	2,329	24	14	0	1	0	39
Puerto Rico	685	63	7	0	0	0	70
Rhode Island	187	33	1	2	0	0	36
South Carolina	807	3	6	5	3	0	18
South Dakota	140	0	5	1	2	4	12
Tennessee	1,094	22	5	1	1	0	28
Texas	3,137	15	4	2	1	1	23
Utah	295	20	11	0	4	1	36
Vermont	116	0	1	1	4	0	7
Virgin Islands	9	1	0	0	-	0	1
Virginia	1,186	3	4	1	4	1	15
Washington	1,013	21	6	0	1	0	28
Washington D.C.	80	2	1	0	0	7	10
West Virginia	389	1	15	2	2	3	23
Wisconsin	938	15	11	1	2	3	32
Wyoming	83	0	1	0	3	1	6

Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports to CMS rather than bids. Totals may not sum due to rounding.

Source: CMS enrollment and population data, 2012.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2012

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	112%	112%	114%	107%	112%
Bids/FFS	98	95	108	100	106
Payments/FFS	107	106	113	105	110

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of plan bid data from CMS, October 2011.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

- The benchmark is an administratively determined bidding target. Legislation established the formula, being phased in by 2017, for calculating benchmarks in each county, based on percentages (ranging from 95% to 115%) of each county's per-capita Medicare spending.

- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating and is phased in so that in 2014 it will range from 50 percent to 70 percent. (In 2011, all plan rebates were set at 75 percent.) The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.

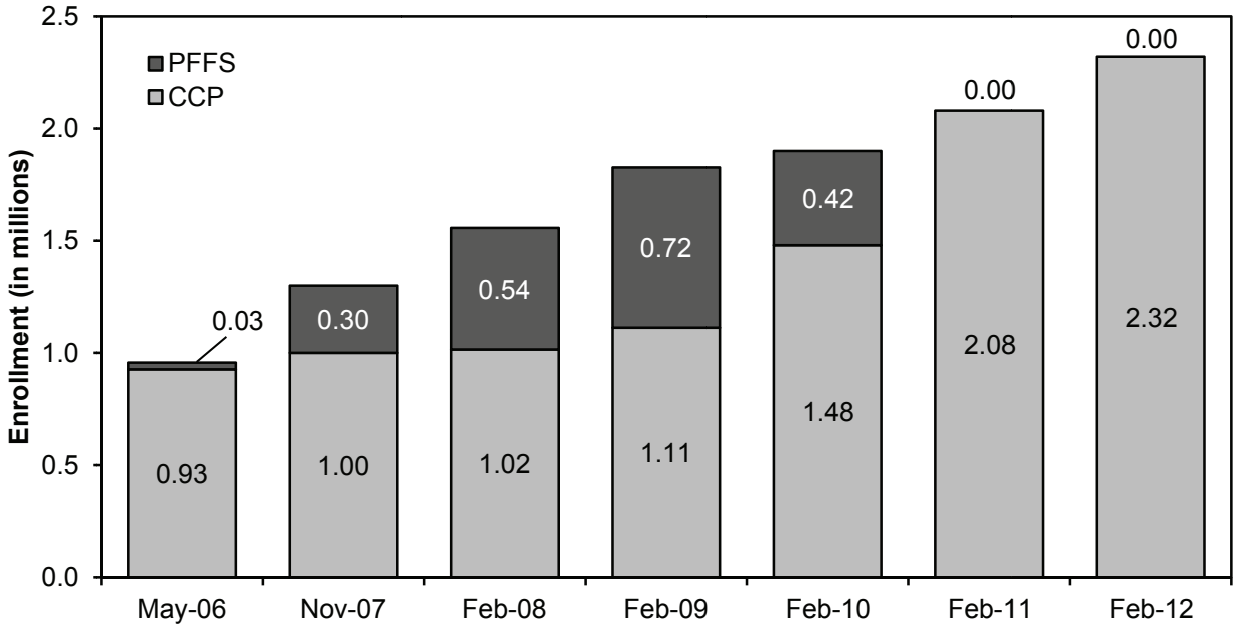
- We estimate that MA benchmarks average 112 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.

- Plans' enrollment-weighted bids average 98 percent of FFS spending. We estimate that HMOs bid an average of 95 percent of FFS spending, while bids from other plan types average at least 100 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid, while other plan types tend to charge more.

- We project that 2012 MA payments will be 107 percent of FFS spending. It is likely this number will decline significantly over the next few years as benchmarks are gradually reduced relative to FFS levels to meet requirements under the Patient Protection and Affordable Care Act of 2010.

- The ratio of payments relative to FFS spending varies by the type of Medicare Advantage plan. HMOs and regional PPO payments are estimated to be 106 percent and 105 percent of FFS, respectively, while payments to PFFS and local PPOs will average 110 percent and 113 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2012



Note: MA (Medicare Advantage), PFFS (private fee-for-service), CCP (coordinated care plan).

Source: CMS enrollment data.

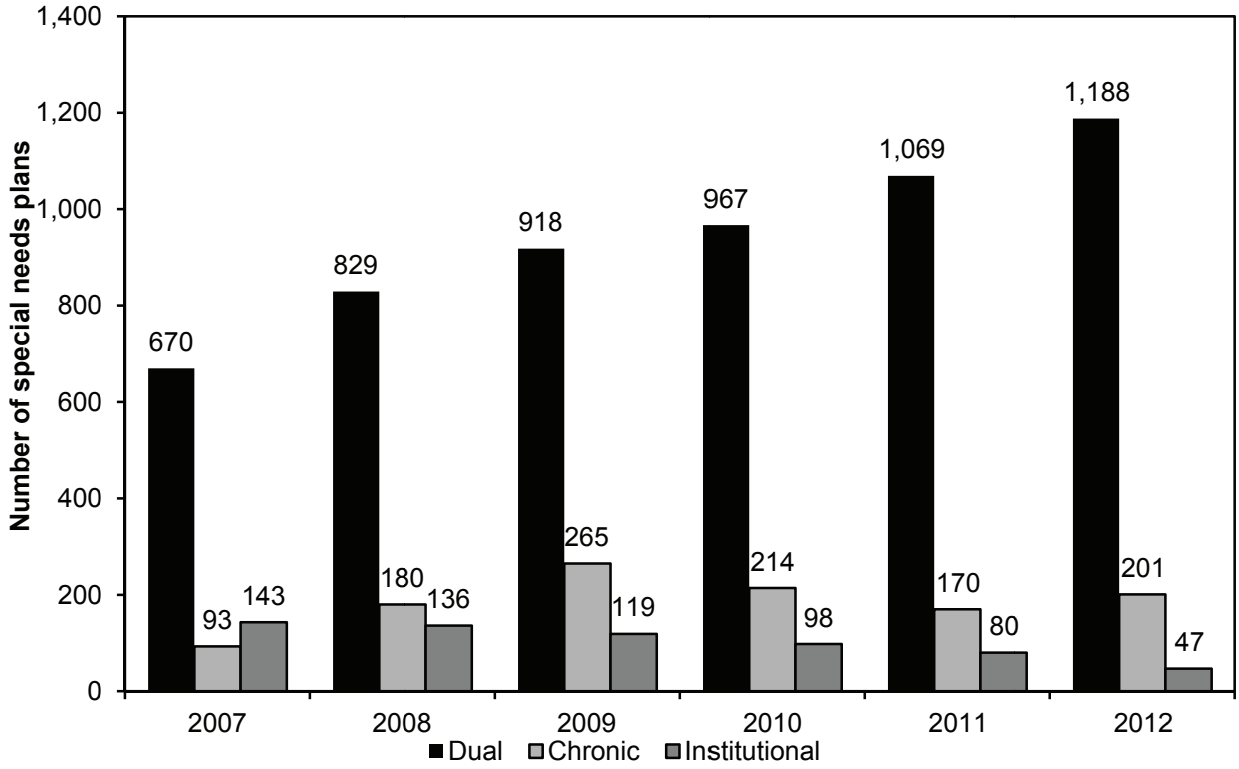
- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions, rather than to individual beneficiaries.

- Enrollment in employer group plans has more than doubled since 2006, while overall MA enrollment grew by about 82 percent. As of February 2012, about 2.3 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.

- Under a requirement in the Medicare Improvements for Patients and Providers Act of 2008, employer group plans were required to have networks and after 2010 could no longer be PFFS plans.

- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to FFS spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 108 percent of FFS, compared with 96 percent of FFS for individual plans (not shown in chart above).

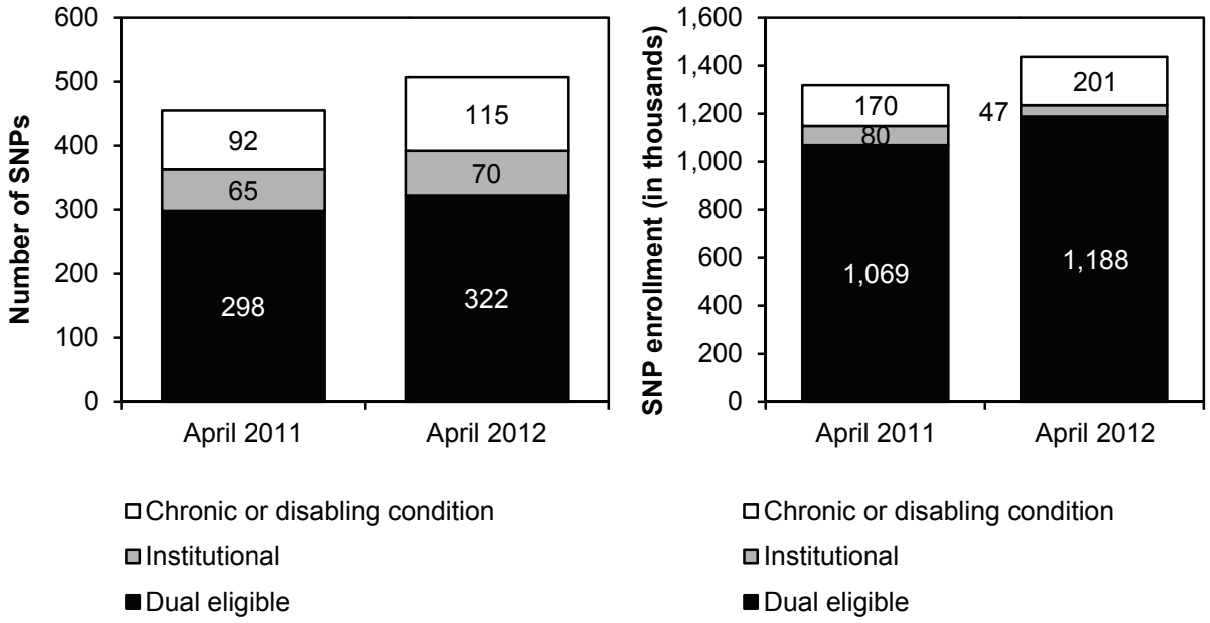
Chart 9-8. Number of special needs plan enrollees, 2007–2012



Source: CMS special needs plans comprehensive reports, May 2007, April 2008, April 2009, April 2010, April 2011, and April 2012.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- SNPs were originally authorized for five years. SNP authority was extended, subject to new requirements, by the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, and the Patient Protection and Affordable Care Act of 2010. Absent congressional action, SNP authority will expire at the end of 2014.
- CMS approves three types of SNPs: dual SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid; chronic SNPs enroll only beneficiaries who have certain chronic or disabling conditions; and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing home certified.
- Enrollment in dual SNPs has grown continuously and is about 1.2 million in 2012.
- Enrollment in chronic SNPs has fluctuated as plan requirements have changed.
- Enrollment in institutional SNPs has declined steadily.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2011 to 2012



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2011 and 2012.

- The number of SNPs increased by 11 percent from April 2011 to April 2012, and the number of SNP enrollees increased by 9 percent.
- In 2012, most SNPs (64 percent) are for dual-eligible beneficiaries, while 23 percent are for beneficiaries with chronic conditions, and 14 percent are for beneficiaries who reside in institutions (or reside in the community, but have a similar level of need).
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to 1.4 million in April 2012.
- The availability of SNPs has changed slightly and varies by type of special needs population served. In 2012, 78 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 76 percent in 2011), 41 percent live where SNPs serve institutionalized beneficiaries (down from 47 percent), and 45 percent live where SNPs serve beneficiaries with chronic conditions (down from 46 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, defined in the CMS–HCC model, 2008

Conditions (defined by HCCs)	Percent of beneficiaries
Diabetes without complications	13.0%
Breast, prostate, colorectal, and other cancers	7.0
Diabetes with renal or peripheral circulatory manifestation	3.8
CHF	3.0
Diabetes with neurologic or other specified manifestation	2.7
COPD	2.5
Rheumatoid arthritis	2.3
Specified heart arrhythmias	2.3
Vascular disease	2.2
Major depressive, bipolar, and paranoid disorders	2.2
Angina pectoris/old myocardial infarction	1.6
Diabetes with ophthalmologic or unspecified manifestation	1.5
Polyneuropathy	1.3
Lymphatic, head and neck, brain, and other major cancers	1.2
Breast, prostate, colorectal, other cancers; plus diabetes without complication	1.2
Diabetes without complication; plus CHF	1.1
Diabetes with neurologic or other specified manifestation; plus polyneuropathy	0.9
Renal failure	0.9
CHF and specified heart arrhythmias	0.9
Diabetes with renal or peripheral circulatory manifestation; plus polyneuropathy	0.8
Total	52.3

Note: MA (Medicare Advantage), HCC (hierarchical condition category), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare data files from Acumen LLC.

- CMS uses the CMS–HCC model to risk adjust capitated payments to MA plans. The CMS–HCC uses beneficiaries' conditions that are collected into HCCs to adjust the capitated payments.
- The CMS–HCC includes 70 HCCs, which represent a broad spectrum of conditions. Five of the 70 HCCs represent diabetes categories that vary by severity.
- The five diabetes HCCs are part of 7 of the 20 most common HCC combinations. Other common conditions are congestive heart failure, chronic obstructive pulmonary disease, and various cancers.

Chart 9-11. Distribution of MA plans and enrollment by CMS overall star ratings, April 2012

Plans and enrollment	Star rating: number of stars							
	5	4.5	4	3.5	3	2.5	2	Any star rating
All plan types								
Number of plans	9	46	51	119	144	65	13	447
Enrollment (in thousands)	1,146	1,314	1,267	4,408	3,415	1,080	36	12,665
As percent in rated plans	9%	10%	10%	35%	27%	9%	0.3%	100%
HMOs								
Number of plans	9	38	39	73	87	51	4	301
Enrollment	1,146	1,152	1,076	2,854	1,712	845	29	8,814
As percent of HMO enrollees	13%	13%	12%	32%	19%	10%	0.3%	100%
Local PPOs								
Number of plans	0	8	11	43	40	10	2	114
Enrollment	0	162	190	1,528	684	136	6	2,707
As percent of local PPO enrollees	N/A	6%	7%	56%	25%	5%	0.2%	100%
Regional PPOs								
Number of plans	0	0	0	1	9	2	0	12
Enrollment	0	0	0	21	856	36	0	914
As percent of regional PPO enrollees	N/A	N/A	N/A	2%	94%	4%	0%	100%
PFFS								
Number of plans	0	0	1	2	8	2	0	13
Enrollment	0	0	<1	4	163	63	0	229
As percent of PFFS enrollees	N/A	N/A	0.1%	2%	71%	28%	0%	100%

Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available). For purposes of this table, a plan is a Medicare Advantage contract, which can consist of several options with different benefit packages that are also referred to as "plans." Numbers may not add to 100 percent due to rounding.

Source: MedPAC analysis of CMS star ratings and enrollment data, 2012.

- The star rating system is a composite measure of clinical processes and outcomes, patient experience measures, and measures of a plan's administrative performance. The overall star rating measures performance on Part C measures and Part D measures.

- The average overall star rating across all plans is 3.36, or 3.57 on an enrollment-weighted basis. There are 115 plans, with 548,000 enrollees, that do not have a star rating because they are too new to be rated or there is insufficient information on which to base a rating.

(Chart continued next page)

Chart 9-11. Distribution of MA plans and enrollment by CMS overall star ratings, April 2012 (continued)

- Under a program-wide demonstration, beginning in 2012, plans with ratings at 3 stars or above receive bonus payments in the form of an increase in their benchmarks. Plan star ratings also determine the level of rebate dollars, though the demonstration does not change the statutory provisions specifying the rebate levels for different star ratings.

- Under the statutory provisions that introduced quality bonus payments, only plans at 4 stars or above would have received bonuses. Under the demonstration, only 10 percent of enrollees are in plans not receiving quality bonuses (2.5- and 2-star plans), whereas under the statutory provisions 71 percent of enrollees would have been in plans not receiving a quality bonus.

- HMOs are the only plan type for which there are 5-star plans. The highest star rating attained by any local PPO is 4.5, whereas the highest rating for a PFFS plan is 4.0 (for one plan), and the highest rating achieved by any regional PPO is 3.5 (one plan).

  Under the statutory bonus provisions, no regional PPOs or PFFS plans would have received bonus payments. For local PPOs, 87 percent of enrollees would have been in plans not receiving bonus payments.

- The criteria for determining plan star ratings change from year to year. Plan ratings across years are, therefore, not entirely comparable. Between 2011 and 2012, star rating criteria were changed and a weighting approach was used, with the result that, in 2012, 62 percent of the weight of measures reflects Part C and D clinical quality measures, compared to 49 percent in 2011.

Web links. Medicare Advantage

- Chapter 12 of MedPAC's March 2012 Report to the Congress provides information on Medicare Advantage plans.

  http://www.medpac.gov/chapters/Mar12_Ch12.pdf

- More information on the Medicare Advantage program payment system can be found in MedPAC's Medicare Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_MA.pdf

- CMS provides information on Medicare Advantage and other Medicare managed care plans.

  http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html

  http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html

- CMS star ratings for Medicare Advantage plans can be found at

  http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

  http://www.medicare.gov/